USAF Refractive Surgery (USAF-RS) Program

Managed Care Agreement

_____ _____ ☐USAF ☐USA ☐USN ☐USMC
Patient Name Rank ☐USCG ☐USPHS ☐NOAA

_____ _____ _____
Military Installation Phone E-mail

In the next 6 months, are you: ☐PCSing ☐Separating ☐Retiring ☐Deploying ☐N/A

Refractive Surgery Center: ☐Joint Warfighter, Lackland AFB ☐USAF Academy ☐Wright-Patterson AFB
☐Keesler AFB ☐Travis AFB ☐Andrews AFB ☐Other DoD_____

PATIENT AGREEMENT **(initial each statement)**

_____ I request to be returned to my local eye clinic for post-operative care following refractive surgery at the DoD Refractive Surgery Center listed above. The Refractive Surgery Center staff will be available for additional consultation as needed.

_____ I will contact my local Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my surgery date.

_____ I understand that I must comply with and accomplish all required referral and follow-up evaluations as required by USAF policy. Non-compliance may result in duty restrictions or disqualification.

_____ I will contact my local Optometry Clinic or Primary Care Manager within 3 days of receiving treatment. I am aware that I will be placed on Duty Limiting Condition status after surgery and can not deploy or PCS for up to 4 months after surgery. I understand that I must be evaluated by the base optometry clinic prior to being cleared to resume unrestricted duties.

_____ I understand that I must bring the package of all pre-operative evaluations, surgical reports, and follow-up exams provided by the Refractive Surgery Center to my local optometry clinic for inclusion in my military medical records.

_____ _____
Patient Signature Date

Post-Operative Appointment Schedule:

AASD: 1, 3, 6, 12, and as required for waiver renewal.
Warfighter: 1, 3, 6, 12 months
Note: ASA (PRK, LASEK, Epi-LASIK, WFG-PRK) requires a 2 month pressure check

REFERRING DOCTOR'S AGREEMENT

I certify that I have attended the USAF-RS Co-Management Course. I will manage this patient and accept responsibility for his/her post-operative care. I agree to refer this patient promptly if a condition arises post-operatively that will require further treatment by the Refractive Surgery Center.

_____ _____
Referring Optometrist Stamp/Signature Date

_____ _____ _____ _____
Military Installation Phone Fax E-mail